America's Blood Centers

OUR MEMBERS SERVE COMMUNITIES NATIONWIDE

725 15th Street, NW ♦ Suite 700 ♦ Washington, DC 20005 ♦ 202-393-5725 ♦ 1-888-USBLOOD ♦ FAX 202-393-1282
Web Site: http://www.americasblood.org ♦ e-mail: abc@americasblood.org

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Via Hand Delivery

Dockets Management Branch (HFA-305)
Food and Drug Administration
5630 Fishers Lane
Room 1061
Rockville, Maryland 20852

Docket No. 99D-1878

Guidance for Industry Current Good Manufacturing Practice for Blood and Blood Components: (1) Quarantine and Disposition of Units from Prior Collections from Donors with Repeatedly Reactive Screening Tests for Antibody to Hepatitis C Virus (Anti HCV); (2) Supplemental Testing, and the Notification of Consignees and Blood Recipients of Donor Test Results for Anti HCV.

To whom it may concern:

These comments are filed by America's Blood Centers representing independent, not-for-profit community blood centers who collect, process and distribute approximately half the US volunteer donor blood supply. We appreciate the opportunity to comment, and the attention, which the agency has always given to our input.

The guidance incorporates extension of lookback to include HCV 1.0. The guidance appears to be a reasonable approach to a subject of significant controversy.

The following comments relate to the areas in which we have the greatest concern.

TIME FRAMES

1. Extension beyond 1988

We did not expect the requirement to "identify prior collections extending back indefinitely to the extent that electronic or other readily retrievable records exist". This raises the "lookback

99D-1878 C13

bar" to an unreasonable level which, in our opinion, does not serve the public health objectives of the lookback initiative that have previously been well articulated. Also, the term "readily retrievable" lacks a standard definition. Further clarification of this term is needed for a firm to assure compliance with the indefinite lookback requirements. The risk of each institution formulating its own policy undermines the uniform public health effort driving lookback.

We oppose this requirement for the following reasons:

It will greatly slow present lookback efforts. The current effort focused on EIA 2.0/3.0 repeatedly reactive donors is very time consuming for both blood collection facilities and hospital transfusion services. This open-ended extension of the lookback with the addition of HCV 1.0 will require an intense manual effort by both collection and transfusion facilities. In order to meet this new requirement, it becomes necessary to locate and review the actual test results (both initial and repeat), and perform the S/CO calculation for the HCV 1.0 repeatedly reactive donors.

In addition, this requirement will force reopening of all HCV 2.0/3.0 lookback cases, many of which have already been completed. This major commitment of resources must be done without the knowledge of whether the hospital has the ability to access these records. The specific consignee hospital is not identified until after the donor test record has been researched, so even if it is known that a particular hospital does not have records, the blood collection agency must still do the initial work. Inasmuch as transfusion service records previously were only required to be kept for 5 years (more recently, for 10) and given the mortality of transfusion recipients from underlying disease, there will be little value achieved from this extension. If no records are available, the end result of this effort is that there will be no recipient notification, which is in contradiction to the intent of the document.

We believe that resources used in this new requirement will be more appropriately applied to completing the 2.0/3.0 process already underway prior to starting HCV 1.0 lookback.

According to the July 1999 AABB progress survey of 171 blood collection facilities, 38 facilities (22%) have completed 25% or less of the required record review and 56 facilities (33%) have completed 25% or less of consignee notifications. In that same survey, only 99 facilities (58%) have completed the record review and only 69 facilities (40%) have completed consignee notification, so it is clear that resources should be directed to completing the HCV 2.0/3.0 lookback which, as we know from historic and the current lookback, are most likely to find living blood recipients for testing. The progress survey also shows that records indicated 4,183 of 10,088 (42%) of identified recipients were deceased. These numbers are consistent with the CJD Lookback Study being conducted by the National Blood Data Resource Center in which data through June 1999 shows that of 283 identified recipients, 158 or 56% were deceased.

Additional data on the rate of identified individuals who were already deceased has been compiled from the effort to date on HCV 2.0 retrospective lookback. In Pittsburgh, three tertiary hospitals evaluated 1,125 recipients and 603 (54%) were deceased; one Children's hospital evaluated

97 recipients, and 55 (57%) were deceased and; three community hospitals evaluated 108 recipients and 78 (72%) were deceased. The overall mortality rate was 738/1,330 or 55%.

Comprehensive data from a Midwest hospital served by the Mississippi Valley Regional Blood Center has also been compiled. This hospital identified 141 components that were subject to lookback and located 113 records in which transfusion had occurred. Fifty-five (55) potentially exposed recipients (49%) of 113 components were found to be dead on query of the Social Security Death Index. The final number of deceased recipients rose to 63 (56%) after aggressive recipient notification efforts. Out of 58 successful notifications, 43 recipients were reached and 40 were tested. Of the 40 that were tested, 3 tested positive, with one of them already being aware of the positive test results. Thus researching 141 components lead to finding 3 affected recipients, of whom one already knew.

We believe this is a representative scenario, and it is ill advised and impractical to extend the lookback beyond the current required time frame, since as records get older, yield will decline.

ABC reminds FDA that lookback was intended to be a two pronged approach, to be conducted in tandem with a CDC effort to inform the general public that anyone transfused prior to 1992 should be tested for HCV. We still believe that this mechanism will be more beneficial and can be done in a timelier manner than extension of the targeted lookback beyond 1988.

Further, the Advisory Committee on Blood Safety and Availability considered this matter in detail, and recommended the 1988 cutoff. If this guidance is to be consistent with that recommendation, then the 1988 cutoff must be restored.

We most urgently request that extension beyond 1988 be deleted.

2. Beginning 1.0 lookback before completion of 2.0/3.0

We believe the requirements for 1.0 lookback are reasonable but we are concerned about trying to complete it during the same time frame in which we are trying to complete lookback already underway for 2.0/3.0. As referred to above, the effectiveness of lookback must decline in proportion with interval since the transfusion event. In view of this, 2.0/3.0 lookback represents the best opportunity to identify and refer potential patients for evaluation. The identification of HCV infected blood recipients must remain the highest priority in this effort.

We request that 1.0 consignee notification be required to begin by May 1, 2000 and be completed by May 1, 2001. Transfusion Services should have one year following notification to complete recipient notification and must have completed it by May 1, 2002.

3. Prospective lookback

ABC also requests that a rolling ten years become the required time frame for all new prospective lookbacks.

If 1988 is retained as the time frame, then in each succeeding year, the number of years for which records must be reviewed will gradually keep increasing. Since the new records retention requirement is for ten years, it is more appropriate to adopt a time frame for lookback that is consistent with the ten years in which transfusion records are expected to be available.

4. Quarantine

Three (3) calendar days is an unrealistic expectation for identification and quarantine of prior collections and notification of consignees to quarantine prior collections whenever a donor tests repeatedly reactive. We continue to support changing this time to 7 days as it was in the July 1996 memorandum. However, failing that, we request that the wording be changed to 3 working days.

ADDITIONAL CONCERNS

1. Autologous donor notification

We believe it is unnecessary to include autologous donors in the notification efforts, since it is standard practice to notify the patient's physician of the repeatedly reactive HCV test result at the time the autologous unit was collected and as is required in the FDA memo to all registered blood establishments on September 11, 1991 titled "Disposition of Blood Products Intended for Autologous Use That Test Repeatedly Reactive for Anti HCV" This memo also requires collection facilities to indefinitely defer these donors for homologous donation, so the donor will also have been notified of the HCV test result.

We request deletion of "NOTE: FDA recommends that blood establishments notify the physicians of autologous donors of the donor's repeatedly reactive test results and supplemental test results, when applicable, for the purpose of medical follow-up and counseling." This note appears in of section 3C and 2 B.

2. Physician identification

Section 4. Notification of Transfusion Recipients part b requires identification of both the patient's physician of record and the physician responsible for the transfusion order. In part c (i) and (ii) the requirement is to notify the physician of record or the physician that ordered the blood. We believe it is unnecessary to identify both.

We request that the wording in part b be changed to require identification of either the patient's physician of record or the physician responsible for the transfusion order.

MINOR INCONSISTENCIES

There are some minor inconsistencies that we would like to bring to your attention. Throughout the document the term "are at increased risk of transmitting HCV" has been substituted for "may have contained HCV" which was used in the previous guidance. However, Section 4 Notification of Transfusion Recipients, introductory paragraph and part c, uses the term "potentially contained HCV", but section e and f uses the terminology "increased risk of transmitting HCV".

Section 2A specifies "donations of blood and blood components intended for transfusion". Section 3A does not include this specification.

Section 2A lists three exceptions. Section 3A has only two exceptions. We believe that exception 1) "There is no recommendation for quarantine of Source Plasma or Recovered Plasma based on retrospective review of records because few if any unpooled prior collections exist" should be added to Section 3A.

Item 3.B.1.(i) is not logical. If the supplemental test is not performed, consignees cannot be notified of the results of supplemental testing.

We repeat our appreciation of the invitation to comment and of the FDA's consideration of our positions.

Sincerely,

Celso Bianco M.D.

Celso Bianco, M.D.
President

Mary Townsend M.D.

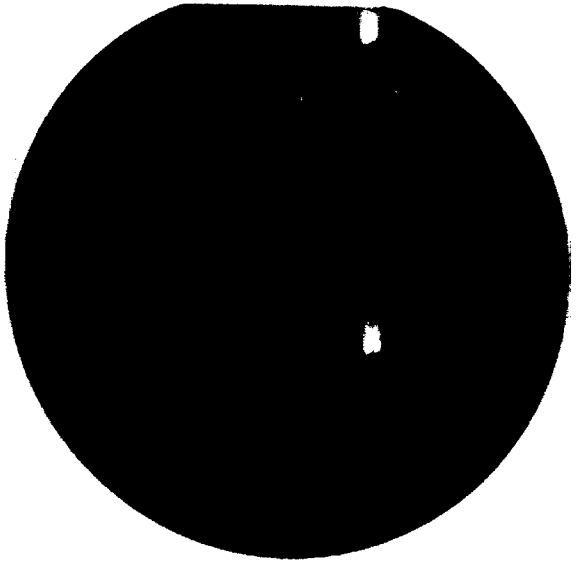
Mary Townsend, M.D.
Chair, Scientific, Medical and Technical Committee

Louis Katz M.D.

Louis M. Katz, M.D.
Vice-Chair, Scientific, Medical and Technical Committee

erica's Blood
Centers

TO COMMUNITIES NATIONWIDE
th Street, NW ♦ Suite 700
Washington, DC 20005



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Food and Drug Administration
5630 Fishers Lane
Room 1061
Rockville, Maryland 20852
Phone ~~1-888-463-6332~~ 301-827-6860

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